HEALTH CARE POLITICS AND COST CONTAINMENT*

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I am here today because during the period from 1976 to 1978 I was a volunteer consultant to the mayor's office and the New York City Health and Hospitals Corporation. Unfortunately, during that phase of the fiscal crisis some $100 million were cut from public health care programs. These health care reductions hurt because, despite efforts to improve efficiency, fiscal savings of this size could be achieved only by eliminating essential services and reducing the quality of the city's public health care programs. In the Academy's invitation it was suggested that I try to relate this past experience to the current situation, where fiscal problems and politics are again mixing together, as they do inevitably, this time perhaps forcing some fairly drastic changes in the health care system.

I came away from that experience with great admiration for the people who work in New York City's municipal hospital system and with an appreciation for the tremendous need New York City has for such a system at this time. Approximately three million people depend on the municipal system for their health care. The municipal system provides about 20% of New York's inpatient hospital care. As in many large urban centers in the United States, the municipal system also provides approximately 50% of the hospital based ambulatory care available in New York through the city's outpatient clinics and hospital emergency rooms. Since office based physicians have virtually disappeared from many urban neighborhoods, the municipal system has become family doctor to the city's low and moderate income groups, particularly the elderly and black and Hispanic communities. Available data suggest that the city's municipal hospital system is a cost effective provider of essential health care services, which would

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have to be purchased from other sources at higher costs were the municipal system to be dismantled.

Like most people involved in the health care field, I also came to appreciate the need for reforms in how we deliver care. We need to reorient priorities to put more emphasis on ambulatory care and preventive medicine, and reduce our reliance on hospital treatment; to make the system more economical; and to provide a more equitable means of financing care so that all segments of the population have access to quality health care.

At present there seems to be no rational way to make some of the reforms that everybody agrees have to be made. There seems to be no way to reconcile various conflicting interests. In these circumstances, cost containment efforts mainly reflect battles over the structure of our health care system and the degree of government control rather than efforts to improve efficiency in the practice of health care, the microeconomics of its delivery, or both.

Cost containment on a local level means closing hospitals and clinics in an attempt to reduce public spending. Throughout the country, municipal health care systems and health departments have been seriously hurt by local fiscal cutbacks, and the private and public medical sectors have been put in a position where they must compete for limited health care dollars. In some cases this competition has helped to destroy certain basic public health functions such as the well-baby and other screening programs of health departments, epidemiologic capabilities, and basic vaccination programs and school health programs. In addition, the delivery of quality care through public hospitals and clinics has been cut back and underfunded to a point where critical failures in patient care occur. On the federal level, cost containment means legislation to limit annual increases in health care costs to some rate in the range of 10% to 11% per year.

Thus, the general thrust of cost containment has been reflected in two general policies by federal and local governments. First, an effort to cut back the scope of services and levels of funding for public health care programs and, second, Washington proposes to broaden governmental controls over the financing, planning, and delivery of private sector health care and to institute price controls on hospital care.

The two policies are linked by the anticipation that in the future, when the United States enacts some form of comprehensive health insurance, public health care delivery programs will be less essential. The logic of

most national health insurance proposals requires detailed controls on fee schedules and utilization, lest increased insurance coverage accelerate inflation and increase the possibilities for abuses. Understandably, physicians and other segments of the health care field will resist such regulations. It is hard for a consumer to have any confidence that the type of government regulation required by both the president's and Senator Edward Kennedy's proposals can be made to work. Many public health advocates have doubts and therefore have been pushed to the extreme of declaring that national health insurance will not work and that what we need is a national health service.

In my opinion, except for a limited form of catastrophic insurance coverage, there is little chance of political agreement on national health insurance or a national health service within the next 10 years because not enough physicians would find it acceptable to work in a highly regulated or nationalized industry and not enough people have sufficient confidence in the ability of the government to regulate or to assume direct control of the entire health care system.

However, there is a long tradition of an important, limited role for public hospitals and health departments:

1) Many physicians prefer to work in the public sector.

2) Many private hospitals prefer that public hospitals serve certain geographic areas and populations and concentrate on certain services which are difficult, unremunerative, or both.

3) Many people throughout the country rely on public hospitals and health departments as protectors of the public's interests and health.

We have an opportunity to marshal the combined strength and capabilities of the municipal systems throughout the United States which, according to the recent report of the Commission on Public-General Hospitals, account for 24% of all hospital beds and 28% of all outpatient visits, have 577,000 employees, and are important providers of care in both urban and rural areas.[1]

These systems should be linked by new legislation providing for common operating standards and policies and access to federal funds for such targeted activities as ambulatory and preventive care, programs for the poor and aged, and care for people who have exhausted their existing health insurance coverage (i.e., to prevent catastrophic financial ruin).

Then we would have a partial national health service built on institutions already structured to reduce the impact of inflation on health care costs

because they are based on a salaried, professional staff rather than a fee-for-service system, are publicly accountable, and have a long history of commitment to such cost-containing activities as ambulatory care, prevention, rehabilitation, public health education, and fiscal accountability.

The key point is that while an all embracing national health service would be unacceptable, a *partial* national health service as an alternative, complementary mode of delivery might be feasible because a large segment of the medical profession and the public would support it.

Certainly, such an approach appears to be worth considering on the basis of the beneficial economic impact the Health and Hospitals Corporation seems to have had in New York. Compared to the 50 largest United States cities, New York had 18% fewer hospital beds and 32% fewer admissions per capita, based on the latest available data for 1975.[2] New York does have a higher average length of stay, partly due to older and more seriously ill people in widely diverse areas of the city. On balance, it seems clear that New York has been able to reduce the number of inpatient hospital days per capita more than other cities with comparable needs. Even a 10% to 15% net savings (less than half of the 32% savings on per capita admissions) would mean $500 million to $750 million in economic benefits when related to the $5-plus billion spent in New York for hospital care.

How has New York been able to economize on inpatient care as compared to the fifty largest cities? Federal policy makers should be forced to confront this question. I suggest that a large part of the answer is the commitment to ambulatory and preventive care made through the municipal system and the health department in New York, which has reduced the number of hospital admissions. Another key factor that has helped New York City to economize on hospital costs and inpatient days is a municipal system based on a salaried professional staff without personal monetary incentive to encourage unnecessary admissions or procedures. This has led to reduced inpatient days and lower costs per hospital day.[3]

REFERENCES

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